Residential care and cure

Harder, Annemiek T.

Published in:
Residential Treatment for Children and Youth

DOI:
10.1080/0886571X.2018.1460006

Publication date:
2018

Residential Treatment for Children & Youth

ISSN: 0886-571X (Print) 1541-0358 (Online) Journal homepage: https://www.tandfonline.com/loi/wrtc20

Residential Care and Cure: Achieving Enduring Behavior Change with Youth by Using a Self-determination, Common Factors and Motivational Interviewing Approach

Annemiek T. Harder

To cite this article: Annemiek T. Harder (2018) Residential Care and Cure: Achieving Enduring Behavior Change with Youth by Using a Self-determination, Common Factors and Motivational Interviewing Approach, Residential Treatment for Children & Youth, 35:4, 317-335, DOI: 10.1080/0886571X.2018.1460006

To link to this article: https://doi.org/10.1080/0886571X.2018.1460006

RESIDENTIAL TREATMENT FOR CHILDREN & YOUTH
2018, VOL. 35, NO. 4, 317–335
https://doi.org/10.1080/0886571X.2018.1460006

Routledge
Taylor & Francis Group

Residential Care and Cure: Achieving Enduring Behavior Change with Youth by Using a Self-determination, Common Factors and Motivational Interviewing Approach

Annemiek T. Harder

Department of Special Needs Education and Youth Care, University of Groningen, Groningen, The Netherlands

ABSTRACT

Residential treatment for youth includes both care, such as basic care-taking tasks and pedagogical child-rearing tasks, and cure elements, such as the therapeutic milieu and individual treatment plans. With these elements, residential treatment aims to achieve a healthy development and a decrease of the present problems with youth. However, achieving enduring change with youth after they have left residential treatment is a great challenge. This challenge can be explained by care workers' difficulties to establish good, genuine therapeutic relationships with individual youth. Furthermore, it can be explained by the commonly used treatment approach to achieve behavior change with youth during residential care. In this paper, I suggest that higher long-term effectiveness of residential treatment can be achieved by applying a combination of three treatment approaches. First, by focusing on youth's individual needs and intrinsic motivations using the Self-Determination Theory (SDT) perspective. Second, by using the Common Factors model as residential care element to promote professionals' interpersonal skills and good, genuine therapeutic relationships with youth. Third, by applying the Motivational Interviewing (MI) approach as a residential cure element. By integrating these approaches as intervention components, it is very likely that residential treatment will contribute to more enduring behavior changes with youth.

KEYWORDS

therapeutic residential youth care; adolescents; Self-Determination Theory; Common Factors model; motivational interviewing

Introduction

Adolescents with complex needs and serious risk behaviors often end up in residential treatment, which is a 'last resort' for those whose problems could not be addressed by other interventions (Hellinckx, 2002; Whittaker, del Valle, & Holmes, 2015). Since at least two decades, residential youth care is seen as a type of care that should be avoided and used as least as possible. Several problem areas appear to exist with regard to residential care, including its relatively high costs, a growing preference for (cheaper and more

CONTACT Annemiek T. Harder A.T.Harder@rug.nl Faculty of Behavioral and Social Sciences, Department of Special Education and Youth Care, University of Groningen, c/o A.T. Harder, Grote Kruisstraat 2/1, 9712 TS Groningen, The Netherlands.

'normalized') family-based treatment alternatives, concerns about attachment in particular for younger children placed in residential care, and fear of abuse, neglect and negative peer influences within residential settings (i.e. a lack of safety). Consequently, treatment foster care is generally considered as a more desirable alternative to residential treatment (Whittaker et al., 2015).

There are different reasons for placing youth in residential youth care. Residential care is suggested when a young person 'is presenting with significant multiple, actionable, behavioral–emotional [i.e. complex] needs and multiple dangerous behaviors' (Lyons, Obeid, & Cummings, 2015, p. 64). For example, these adolescents show risk behaviors, such as suicide risk, self-mutilation, being a danger to others and delinquency (Lyons et al., 2015). Besides individual problems, young people in residential care regularly experience family difficulties. These family difficulties include problems in their relationship with parents and the incapacity of parents to handle their child's problems (Harder, Knorth, Kalverboer, Tausendfreund, & Knot-Dickscheit, 2017). Although all youth in out-of-home care experience serious and multiple problems, youth in residential care show the most serious problems in comparison to youth in foster care and family-style group care (Leloux-Opmeer, Kuiper, Swaab, & Scholte, 2016). Research suggests that 'residential treatment works best for very complicated, high-need and high-risk youth' (Lyons et al., 2015, p. 64).

Therapeutic residential care 'involves the planful use of a purposefully constructed, multi-dimensional living environment designed to enhance or provide treatment, education, socialization, support and protection to children and youth with identified mental health or behavioral needs in partnership with their families and in collaboration with a full spectrum of

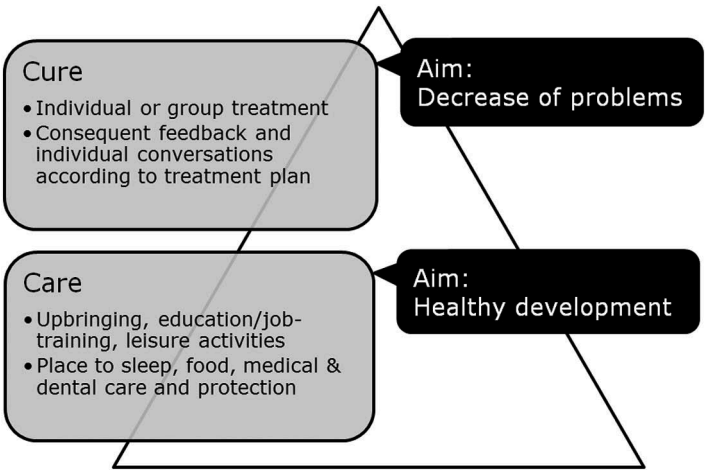

Figure 1. Residential care elements (adapted version of Boendermaker et al., 2013, p. 4; reprinted with permission from the authors).

community-based formal and informal helping resources' (Whittaker et al., 2015, p. 24). To classify the content of residential youth care, Boendermaker, Van Rooijen, Berg, and Bartelink (2013) developed a model in which residential treatment is divided into care and cure elements (see Figure 1).

The care elements involve basic care-taking tasks and pedagogical child-rearing tasks. These basic elements can be considered the primary contributors to the quality of residential care. Protecting the young people by offering a safe environment during care is also one of the basic principles of therapeutic residential care included in a recently published international consensus statement on therapeutic residential care (Whittaker et al., 2016). Cure elements include the therapeutic milieu and individual treatment plans that mainly contribute to the effectiveness of residential care. Both care and cure elements are closely interrelated during residential care and essential to be able to achieve a healthy development and to achieve positive changes in the lives of the young people (cf. Boendermaker et al., 2013).

Although research shows that adolescents generally show positive behavioral changes during residential treatment, these are often difficult to maintain after departure (Knorth, Harder, Zandberg, & Kendrick, 2008). In other words, it is a great challenge 'to achieve *enduring* change (..) that persists over time well after the young person's exit' (Gilligan, 2015, p. 15). This lack of long-term success can on the one hand be explained by the difficult target group. On the other hand, there are different limitations of residential treatment programs that might explain the poor outcomes of youth after their departure from TRC.

Because residential treatment factors make up the instrument that can make a difference in the lives of these young people, it is relevant to consider limitations in the residential care and cure elements that might explain its poor long-term effectiveness.

Limitations in Residential Care: Poor Therapeutic Relationships

First, there can be limitations in the *care elements* that are offered to the young people. A very plausible explanation for the poor outcomes after departure is that it can be difficult for care workers to establish a good, genuine therapeutic relationship with individual young people during care. Difficulties for residential care workers to establish good relationships with young people can, on the one hand, be due to the serious behavioral problems that the young people often show and, on the other hand, to the care worker's inability or lack of skills to build good, genuine relationships with these young people (Harder, Knorth, & Kalverboer, 2013).

With regard to young people's problems, young people in residential care can be poorly motivated for change, which makes it more difficult to achieve a positive alliance (cf. Harder et al., 2013; Karver, Handelsman, Fields, &

Bickman, 2006; Shirk & Karver, 2003). Building a good, genuine relationship with young people may be difficult for residential care workers, because '…it is clearly easier for a therapist to be warm and caring toward a motivated, disclosing and cooperative patient than to one who is interpersonally aggressive…' (Wampold, 2015, pp. 273–274). There are indeed several studies suggesting that a good therapeutic alliance is often difficult to establish with young people showing serious behavioral problems, such as delinquency (Florsheim, Shotorbani, Guest-Warnick, Barratt, & Hwang, 2000; Van Binsbergen, 2003). Research also shows that it is difficult to build a good alliance with youth that have negative expectations about the care they receive (Barnhoorn et al., 2013; Colson et al., 1991), which is regularly the case for youth in residential care because of their previous care histories.

Another possible reason for the difficulty in establishing a good, genuine relationship with young people is that residential care workers do not sufficiently act vigorously in their contact with young people. This is illustrated by the following quote of a 15-year old girl, Susan, staying in a Dutch secure residential youth care facility: 'If there is something the matter with you they often do not notice. If you then say: "There is nothing", then they take that for granted..' (Harder, 2015, p. 302). Residential care workers can have a tendency to avoid difficult situations, i.e. showing 'act embarrassment', in their contact with young people during residential care (Slump, 2011). A possible consequence is that care workers do not establish a good, genuine relationship with young people, but rather a superficial relationship (i.e. 'sham alliance') (cf. Henriksen, Degner, & Oscarsson, 2008).

There is a large amount of research evidence showing that a good therapeutic relationship is highly important for achieving positive care outcomes (e.g. Karver et al., 2006; McLeod, 2011; Wampold, 2015). There appears to be a strong association between good alliances and positive outcomes of care for young people with externalizing behavior (Shirk & Karver, 2003); a group that is often strongly represented in residential youth care (Harder, Knorth, & Zandberg, 2006; Knorth et al., 2008). Furthermore, a positive relationship between a young person and residential care worker is associated with higher treatment satisfaction of youth (Harder, 2011), lower premature departure rates (Grooters, De Swart, Lohuis-Heesink, & Moonen, 2013), higher changes for success after departure (Marsh & Evans, 2009) and lower recidivism rates of youth after departure from residential care (Florsheim et al., 2000).

Limitations in Residential Cure: External Regulation Approach

There can also be limitations in the *cure elements* offered during residential treatment that can explain the relatively poor outcomes of young people after their departure from residential care. Although a lack of family interventions and poor aftercare services are often mentioned as specific

residential cure elements that can explain poor outcomes after residential youth care (e.g. Geurts, Boddy, Noom, & Knorth, 2012; Harder, Kalverboer, & Knorth, 2011), there is another factor that might be even more important in explaining the poor outcomes after care. That factor concerns the treatment approach that is used by residential care workers to achieve behavior change with the adolescents during residential care. Residential or group care workers represent the most important and influential discipline because they have interactions with the young people on a daily basis (Knorth, Harder, Huyghen, Kalverboer, & Zandberg, 2010).

First, many residential treatment approaches or models, including the Teaching Family Model, Re-ED, Stop-Gap model, Sanctuary model, the Lighthouse Therapeutic Family Model, MultifunC, the Family Home Program, CARE model and social competence model (James, 2011; Slot & Spanjaard, 1999; Whittaker et al., 2015), focus (among others) on skills teaching of young people. Although these existing TRC models are more complex than just a focus on skills building, they try to improve adolescent's situation by enhancing their (living, coping and/or social) competences or skills (Durrant, 1993). The models (partly) assume that adolescents show a lack of skills, which caused their problems. However, this main focus on improving competence seems to be (at least partly) inadequate since research has shown that young people in residential care regularly show oppositional problems and poor motivation for change (cf. Englebrecht, Peterson, Scherer, & Naccarato, 2008; Harder, Knorth, & Kalverboer, 2015). Moreover, youth themselves consider their own motivation for behavior change as a key element of the change process during residential treatment (Harder, Knorth, & Kalverboer, 2017; Henriksen et al., 2008). Few of the previously mentioned treatment models, including the Positive Peer Culture model (James, 2011), explicitly focus on promoting young people's motivation for behavior change during residential treatment.

Second, research suggests that some residential care workers use a treatment approach that is aimed at achieving behavior change of the young people with regard to daily routines in the residential care setting instead of behaviors that were the reason for their residential care placement (cf. Drumm et al., 2013; Henriksen et al., 2008). Residential care workers also intuitively apply a controlling approach in handling externalizing behavior problems (Anglin, 2002; Bastiaanssen et al., 2012; Kromhout, 2002; Van Dam et al., 2011; Wigboldus, 2002), which are prominently present with adolescents in residential treatment (Harder, 2011). Such a controlling approach to maintain order on a residential group is associated with poor therapeutic relationships with youth (Harder, 2011) and poor care outcomes (Lipsey, 2009).

Residential workers and treatment programs also regularly use external rewards (e.g. earning tokens that can be exchanged for privileges or goods),

persuasions and confrontations as instruments to achieve behavior change with adolescents (Andreassen, 2015; Bartels, 2001; Drumm et al., 2013; Durrant, 1993; Eenshuistra, Harder, Van Zonneveld, & Knorth, 2016; McCurdy & McIntyre, 2004). However, the use of external regulations, such as confronting, persuading or deterrence by care professionals seems to be ineffective in achieving the desired behavior changes with clients, because external regulation approaches are associated with poor care outcomes (Apodaca & Longabaugh, 2009; Lipsey, 2009; Petrosino, Turpin-Petrosino, & Buehler, 2003). Moreover, this token economy approach is criticized in different studies as being antithetical to individualized, culturally and developmentally appropriate treatment (Drumm et al., 2013; Mohr, Martin, Olson, Pumariega, & Branca, 2009; Mohr & Pumariega, 2004; VanderVen, 1995).

A risk of applying an external regulatory approach by residential care workers (Gilman & Anderman, 2006; Ryan & Deci, 2000b) is that youth will show social desirable behaviors during care to satisfy external demand (cf. Abrams, 2006; Drumm et al., 2013; Eenshuistra et al., 2016; Ryan & Deci, 2000b), since they know what is expected of them and how they should behave (cf. Abrams, 2006). Support for such a treatment mechanism has been found in several studies conducted in secure residential youth care (Abrams & Aguilar, 2005; Abrams, 2006; Englebrecht et al., 2008; Harder, Knorth et al., 2017a; Henriksen et al., 2008). This mechanism can be illustrated by the following statement of a residential care worker about the behavior change of young people during secure residential care: 'At a certain point there is a "click" and then it goes well' (Harder, 2011, p. 59). In other words, youth show behaviors during care that can be seen as indications of improvement, but that are in fact behavioral adaptations of young people to the residential care environment (cf. Abrams, 2006; Drumm et al., 2013; Eenshuistra et al., 2016; Ryan & Deci, 2000b). Although these adaptive behaviors of youth can be very functional during care, for example in terms of improving safety or diminishing the amount of conflicts with care workers, this behavior is mainly performed on the basis of extrinsic motivation. Consequently, this extrinsic motivation for behavior can explain why positive behavior changes of youth *during* residential care are not maintained *after* departure when external demands are removed (cf. Colson et al., 1991; Kromhout, 2002; Ryan, Lynch, Vansteenkiste, & Deci, 2010).

Aim and Research Questions

Considering the different treatment limitations, the great challenge to achieve enduring change with youth and the current lack of consensus on critical intervention components of therapeutic residential youth care (cf. Whittaker et al., 2015), I aim to describe a unifying, consistent treatment approach that

is promising for improving the long-term effectiveness of residential treatment. I will address the following research question: What residential care and cure elements can make a difference with regard to achieving enduring behavior changes with youth in residential treatment? In this paper, I will review several critical intervention components of therapeutic residential youth care that can contribute to more positive long-term outcomes (cf. Whittaker et al., 2015). More specifically, I will draw attention to three approaches that residential programs might want to consider and learn about further.

Youth's Individual Needs and Intrinsic Motivations as a Basic Principle

A first starting point that makes it possible to achieve enduring behavior changes with youth is a residential treatment focus on youth's individual needs and intrinsic motivations. A highly relevant framework that has received much empirical support, but is strikingly neglected in residential treatment is the Self-Determination Theory (SDT) (Ryan & Deci, 2000a; cf. Vansteenkiste & Sheldon, 2006). A basic principle of SDT is that social environments supporting the three basic psychological needs for autonomy, relatedness and competence are important. The need for autonomy refers to the experience of a sense of choice or psychological freedom, the need for relatedness to the desire to feel connected to others, and the need for competence to the ability to affect the environment and to attain desired outcomes within it.

According to the SDT (Ryan & Deci, 2000c; see Figure 2), behaviors that are performed voluntarily (i.e. in the absence of material rewards or external constraints) are necessary to achieve an actual and enduring behavior change

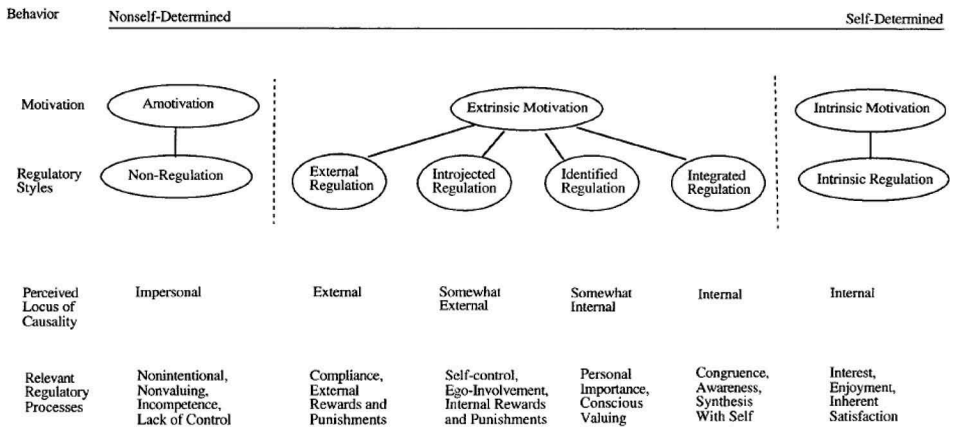

Figure 2. Continuum of self-determination (Ryan & Deci, 2000c, p. 72; reprinted with permission from the authors).

(Deci & Ryan, 2002). SDT assumes that when motivation to change is based on an own decision (autonomy), the person cooperates more actively in treatment to work at an actual change.

SDT distinguishes different types of motivations for behavior (see Figure 2). More self-determined or autonomous motivations are considered more desirable, because they are more likely to lead to sustainable behavior changes than less autonomous motivations and amotivation (Teixeira, Palmeira, & Vansteenkiste, 2012). To develop autonomous motivation an autonomy-supportive treatment approach (i.e. 'empowerment') of youth by care workers is essential (Oliver, Markland, Hardy, & Petherick, 2008; Ryan & Deci, 2008). Besides fulfilling the need for autonomy, SDT proposes that professionals should provide therapeutic support and structure to meet clients' need for relatedness and competence (Miller & Gramzow, 2016; Vansteenkiste, Williams, & Resnicow, 2012).

Research supports that promoting intrinsic motivation for behavior change with clients is important for treatment success (e.g. Barnhoorn et al., 2013; Harder, 2011). Given the empirical support for the SDT framework and its relevance for achieving enduring behavior change with adolescents, residential treatment programs should in the first instance focus on exploring and promoting the intrinsic motivations of young people to show behavioral changes instead of primarily promoting abilities or skills that are desired by the care workers of the residential treatment facility.

Residential Care: Focus on Common Factors and Care Workers as Key to Success

With regard to the residential *care* elements, the 'common factors model' (Karver, Handelsman, Fields, & Bickman, 2005) is a relevant point of departure. The common factors model asserts that personal and interpersonal components common to all therapeutic interventions are responsible for treatment outcomes to a greater extent than specific model ingredients (Barth et al., 2012). According to this model, the most important predictors of child and youth care outcomes are common client and relationship factors, which affect the services offered regardless of the target group or the type of services (Carr, 2009; Karver et al., 2005, 2006). Client factors consist of the factors that are part of the client (e.g. client's problem severity, strengths and motivation for treatment) and his/her context (e.g. social support in the environment). Relationship factors refer to the therapeutic relationship: an emotional connection (e.g. affective bond) and/or a cognitive connection in terms of agreement on the tasks and goals of treatment between a client and a therapist (Karver et al., 2005).

The therapeutic relationship between youth and care workers can be considered an important instrument in residential treatment to achieve behavior change with youth and/or their families (Harder, Hall, & Van Nijnatten, 2016; Karver et al., 2005). Positive therapeutic alliances are strongly associated with good interpersonal skills of care professionals (Baldwin, Wampold, & Imel, 2007; Harder, 2011) and predictive of the level of engagement of clients during treatment (Moyers, Miller, & Hendrickson, 2005). To achieve a good relationship, (residential) care workers' treatment skills, such as being empathic, flexible, honest, respectful, reliable and friendly seem to be essential (Ackerman & Hilsenroth, 2003; Harder et al., 2013; Wampold, 2015). Other examples of good interpersonal skills are showing commitment, warm heartedness, being careful, transparent, and showing an unprejudiced, respectful and appreciating attitude (Barnhoorn et al., 2013). All these skills are associated with positive treatment outcomes (De Swart, 2011; Kane, Wood, & Barlow, 2007; Turney, 2012). Given the importance of good interpersonal skills by professionals, it seems crucial to promote and maintain those skills during residential treatment as a prior condition to achieve enduring behavior change with adolescents.

Residential Cure: Achieving Enduring Change by Motivational Interviewing

The Motivational Interviewing (MI) approach is a relevant starting point within the scope of residential *cure* elements. The MI approach is consistent with SDT, focuses on common factors and on care workers as key to success, and has received much empirical support. MI is a 'collaborative conversation style for strengthening a person's own motivation and commitment to change' (Miller & Rollnick, 2013, p. 12). It provides 'an excellent theoretical

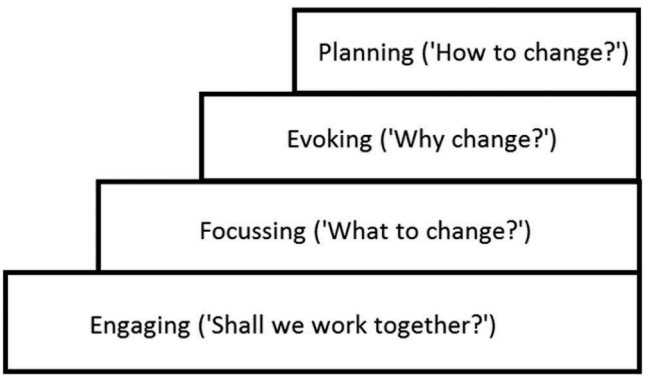

Figure 3. Four processes in MI (Miller & Rollnick, 2013, p. 26; reprinted with permission from the authors).

match' (Feldstein & Ginsburg, 2006, p. 228) with adolescents in residential treatment (Harder et al., 2015; Miller & Rollnick, 2002) since it fits well with the developmental period of adolescence (Barnett, Sussman, Smith, Rohrbach, & Spruijt-Metz, 2012; Naar-King & Suarez, 2011) in which autonomy is important (DiGiuseppe, Linscott, & Jilton, 1996).

A care worker who applies MI is focused on evoking and exploring the client's own reasons to change aims (Miller & Rollnick, 2013). A key MI assumption is that it is the clients' responsibility to decide for themselves whether or not or how to change (Markland, Ryan, Tobin, & Rollnick, 2005). MI 'is designed to strengthen personal motivation and commitment to a specific goal by eliciting and exploring the person's own reasons for change' (Miller & Rollnick, 2013, p. 29). From a SDT perspective, MI can 'successfully promote the internalization of extrinsic change intentions' (p. 68) (Vansteenkiste & Sheldon, 2006) and autonomous motivation for change by providing structure, autonomy support and involvement (Markland et al., 2005, p. 821). MI comprises four overlapping processes (see Figure 3).

The first process, engaging, is focused on the establishment of a working relationship and is a prerequisite for everything that follows. Focussing is the process by which a specific direction in the conversation about change (i.e. change goals) is developed and maintained. Evoking is the core element of MI and involves eliciting the client's own motivations for change. When clients begin to think and talk more about when and how to change and less about whether and why, the final process of planning begins. Both developing commitment to change and formulating a specific plan of action are components of the planning process (Miller & Rollnick, 2013).

A first hypothesized mechanism of action in MI is that by applying MI skills, the therapist evokes client 'change talk' (i.e. client statements in favor of behavior change) (Miller & Rollnick, 2004, 2013) that can predict client outcomes (Magill et al., 2014). Therapists can directly influence change talk by applying MI adherent behavior (Gaume, Bertholet, Faouzi, Gmel, & Daeppen, 2010; Moyers, Martin, Manuel, Hendrickson, & Miller, 2005; Moyers, Rowell, Manuel, Ernst, & Houck, 2016). MI adherent behaviors include being involved (i.e. using the skills open questions, reflective listening and summarizing), supporting autonomy (i.e. by the MI skills emphasizing autonomy, seeking collaboration, and informing and advising with client permission) and competence (i.e. by the MI skill affirming). Client change talk in turn predicts MI adherent therapist behavior (Gaume et al., 2010). Recent research with young adults specifically shows that 'strong' change talk with a higher intensity of inclination toward change (i.e. utterances, such as 'definitely' or 'I swear') is more predictive of positive treatment outcomes than 'weak' change talk (i.e. utterances, such as 'probably' or 'I guess') (Gaume et al., 2016).

A second hypothesized MI mechanism is that the therapist reduces or avoids client ambivalence by softening client 'sustain talk': statements in favor of maintaining (the undesirable) behavior (Miller & Rollnick, 2013). There is evidence that client sustain talk is more likely to be followed by MI non-adherent therapist behavior, and vice versa (Gaume et al., 2010; Moyers & Martin, 2006). MI non-adherent behaviors are confronting and persuading the client to change his/her behavior (Miller & Rollnick, 2013; Moyers et al., 2016). Both therapists' MI non-adherent behavior and adolescents' sustain talk are associated with poor treatment outcomes (Apodaca & Longabaugh, 2009; Magill et al., 2014).

In many studies MI has been demonstrated effective in promoting client behavior change across a range of health arenas, including a reduction in risk behaviors that are often shown by adolescents in residential treatment such as adolescent substance use (Baer et al., 2008; Jensen et al., 2011; Lundahl & Burke, 2009; Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010; Strang & McCambridge, 2004). To ensure treatment success, it is of critical importance to understand what specific treatment skills are most effective in promoting change with adolescents and to know how professionals can apply those skills to influence adolescents during and after residential treatment. Given the empirical support for the MI approach and its relevance for achieving enduring behavior change with adolescents, MI seems to be very relevant to residential care workers as a basic residential cure element.

Discussion

In this paper I aimed to review critical intervention components of therapeutic residential youth care that can contribute to enduring behavior changes with youth in residential treatment (cf. Whittaker et al., 2015). Considering the current limitations in residential care and cure elements on the one hand and existing evidence-based approaches on the other hand, I outlined three elements of a unifying, evidence-based residential treatment approach that are promising for improving the long-term effectiveness of residential treatment (cf. James, 2011; Lee & McMillen, 2017).

First, I have suggested to primarily focus on youth's individual needs and intrinsic motivations during residential treatment by using the SDT perspective. This perspective seems to be the opposite of currently used treatment approaches, which often focus on external regulation of adolescents' behavior (e.g. by using a token economy system) during treatment (Andreassen, 2015; Bartels, 2001; Drumm et al., 2013; Durrant, 1993; Eenshuistra et al., 2016; McCurdy & McIntyre, 2004). SDT is a highly relevant framework that has received much empirical support, but is strikingly neglected in residential treatment. Especially for achieving enduring behavior change with adolescents the SDT framework is relevant.

A second approach that makes it more likely to achieve enduring behavior changes with youth is the common factors model, which can be applied as a residential *care* element. By promoting good interpersonal skills of professionals and by establishing good, genuine therapeutic relationships with individual youth, residential treatment providers are more likely to achieve positive outcomes. These basic conditions can be fulfilled by providing training and supervision of residential treatment professionals with a focus on promoting good interpersonal skills, such as empathy (Ackerman & Hilsenroth, 2003; Harder et al., 2013; Wampold, 2015). This focus on quality guarantee of treatment providers, which is for example also an important element in the Family Home Program (Thompson & Daly, 2015), seems to be a crucial residential care element.

The third approach, MI, brings together the two previously mentioned perspectives and can function as an important basic residential *cure* element. By promoting MI skills, which currently seem to be lacking in residential treatment practice (Eenshuistra et al., 2016), residential care workers are more likely to achieve enduring behavior changes with adolescents. To apply MI skills into actual practice, sufficient training and support of residential treatment professionals are needed (Schwalbe, Oh, & Zweben, 2014). For example, the meta-analysis of Schwalbe et al. (2014) suggests that three to four feedback/coaching sessions are needed to sustain MI skills among trainees. In addition, different measurement instruments that are specifically developed within the scope of MI research and practice make it possible to evaluate whether MI is skillfully applied (Moyers et al., 2016).

In this conceptual paper, I specifically focused on the empirically well supported SDT, Common Factors model and MI approach, which seem to be very relevant approaches to apply in residential treatment. There are, however, different other approaches, such as the 'planned behavior/reasoned action approach' and the 'Information-Motivational-Behavioral (IMB) Skills Model' (Davis, Campbell, Hildon, Hobbs, & Michie, 2015), that are possibly relevant as input for achieving enduring change with adolescents in residential treatment. Furthermore, a treatment approach such as the common elements approach (Lee & McMillen, 2017) and the collaborative problem solving (CPS) model (e.g. Ercole-Fricke, Fritz, Hill, & Snelders, 2016; Greene, Ablon, & Martin, 2006) are also relevant to further explore in the context of residential treatment.

Although there are other models, both SDT, the Common Factors model and the MI approach are evidence-based, promising treatment approaches that are highly relevant for application in residential treatment, because they are able to address the current limitations in residential care and cure elements and fit very well with the main target group of adolescents. Despite these promising fits, up until now limited attention has been paid to these approaches within the context of therapeutic residential care research and practice. Consequently, both researchers and practitioners in

residential treatment should pay more attention to applying SDT, the Common Factors and the MI approach into research and practice. By integrating these approaches as intervention components, it is very likely that therapeutic residential youth care will contribute to more enduring behavior changes with youth.

References

Abrams, L. S. (2006). Listening to juvenile offenders: Can residential treatment prevent recidivism? *Child & Adolescent Social Work Journal*, *23*(1), 61–85. doi:10.1007/s10560-005-0029-2

Abrams, L. S., & Aguilar, J. P. (2005). Negative trends, possible selves, and behavior change. *Qualitative Social Work*, *4*(2), 175–196. doi:10.1177/1473325005052392

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review*, *23* (1), 1–33. doi:10.1016/S0272-7358(02)00146-0

Andreassen, T. (2015). MultifunC: Multifunctional treatment in residential and community settings. In J. K. Whittaker, J. F. Del Valle, & L. Holmes (Eds.), *Therapeutic residential care for children and youth developing evidence-based international practice* (pp. 100–112). London, UK: Jessica Kingsley Publishers.

Anglin, J. P. (2002). *Pain, normality, and the struggle for congruence: Reinterpreting residential care for children and youth*. Binghamton, NY: Haworth Press.

Apodaca, T. R., & Longabaugh, R. (2009). Mechanisms of change in motivational interviewing: A review and preliminary evaluation of the evidence. *Addiction*, *104*(5), 705–715. doi:10.1111/j.1360-0443.2009.02527.x

Baer, J. S., Beadnell, B., Garrett, S. B., Hartzler, B., Wells, E. A., & Peterson, P. L. (2008). Adolescent change language within a brief motivational intervention and substance use outcomes. *Psychology of Addictive Behaviors*, *22*(4), 570–575. doi:10.1037/a0013022

Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology*, *75*(6), 842–852. doi:10.1037/0022-006X.75.6.842

Barnett, E., Sussman, S., Smith, C., Rohrbach, L. A., & Spruijt-Metz, D. (2012). Motivational interviewing for adolescent substance use: A review of the literature. *Addictive Behaviors*, *37*(12), 1325–1334. doi:10.1016/j.addbeh.2012.07.001

Barnhoorn, J., Broeren, S., Distelbrink, M., De Greef, M., Van Grieken, A., Jansen, W., … Raat, H. (2013). *Cliënt-, professional- en alliantiefactoren: Hun relatie met het effect van zorg voor jeugd. Verkenning van kennis en kennishiaten voor het ZonMw-programma effectief werken in de jeugdsector [Client, professionals, and alliance factors: Their association with the effect of youth care. Exploration of knowledge and knowledge gaps for the ZonMw program working effectively in the youth care sector]*. The Hague, The Netherlands: ZonMw.

Bartels, A. A. J. (2001). Behandeling van jeugdige delinquenten volgens het competentiemodel. *Kind En Adolescent*, *22*(4), 211–226. doi:10.1007/BF03060818

Barth, R. P., Lee, B. R., Lindsey, M. A., Collins, K. S., Strieder, F., Chorpita, B. F., … Sparks, J. A. (2012). Evidence-based practice at a crossroads: The timely emergence of common elements and common factors. *Research on Social Work Practice*, *22*(1), 108–119. doi:10.1177/1049731511408440

Bastiaanssen, I., Kroes, G., Nijhof, K., Delsing, M., Engels, R., & Veerman, J. (2012). Measuring group care worker interventions in residential youth care. *Child and Youth Care Forum*, *41*(5), 447–460. doi:10.1007/s10566-012-9176-8

Boendermaker, L., Van Rooijen, K., Berg, T., & Bartelink, C. (2013). *Residentiële jeugdzorg: Wat werkt? [Residential youth care: What works?]*. Utrecht, The Netherlands: Netherlands Youth Institute.

Carr, A. (2009). *What works with children, adolescents, and adults? A review of research on the effectiveness of psychotherapy*. London, UK: Routledge.

Colson, D. B., Cornsweet, C., Murphy, T., O'Malley, F., Hyland, P. S., McParland, M., & Coyne, L. (1991). Perceived treatment difficulty and therapeutic alliance on an adolescent psychiatric hospital unit. *American Journal of Orthopsychiatry*, *61*(2), 221–229. doi:10.1037/h0079253

Davis, R., Campbell, R., Hildon, Z., Hobbs, L., & Michie, S. (2015). Theories of behaviour and behaviour change across the social and behavioural sciences: A scoping review. *Health Psychology Review*, *9*(3), 323–344. doi:10.1080/17437199.2014.941722

De Swart, J. J. W. (2011). *De professionele jeugdzorgwerker: Kenmerken van jeugdzorgwerkers in relatie tot kwaliteit van de jeugdzorg [The professional youth care worker: Characteristics of youth care workers in relation to quality of youth care] (doctoral dissertation)*. Amsterdam, The Netherlands: VU Amsterdam.

Deci, E. L., & Ryan, R. M. (2002). *Handbook of self-determination research*. Rochester, NY: University of Rochester Press.

DiGiuseppe, R., Linscott, J., & Jilton, R. (1996). Developing the therapeutic alliance in child-adolescent psychotherapy. *Applied and Preventive Psychology*, *5*(2), 85–100. doi:10.1016/S0962-1849(96)80002-3

Drumm, R. D., Coombs, R. S., Hargrove, T. D., Crumley, L. P., Cooper, L., & Foster, T. (2013). "You leave in a body bag or you leave on the points system": Participant perceptions of a points and levels system of behavior management. *Residential Treatment for Children & Youth*, *30*(4), 262–279. doi:10.1080/0886571X.2013.842028

Durrant, M. (1993). *Residential treatment: A cooperative, competency-based approach to therapy and program design*. New York, NY: W.W. Norton & Company.

Eenshuistra, A., Harder, A. T., Van Zonneveld, L., & Knorth, E. J. (2016). Look who's talking: A motivational interviewing based observation study of one-on-one conversations between residential care workers and adolescents. *International Journal of Child & Family Welfare*, *17*(1/2), 64–84.

Englebrecht, C., Peterson, D., Scherer, A., & Naccarato, T. (2008). "It's not my fault": Acceptance of responsibility as a component of engagement in juvenile residential treatment. *Children and Youth Services Review*, *30*(4), 466–484. doi:10.1016/j.childyouth.2007.11.005

Ercole-Fricke, E., Fritz, P., Hill, L. E., & Snelders, J. (2016). Effects of a collaborative problem-solving approach on an inpatient adolescent psychiatric unit. *Journal of Child and Adolescent Psychiatric Nursing*, *29*(3), 127–134. doi:10.1111/jcap.12149

Feldstein, S. W., & Ginsburg, J. I. D. (2006). Motivational interviewing with dually diagnosed adolescents in juvenile justice settings. *Brief Treatment and Crisis Intervention*, *6*(3), 218–233. doi:10.1093/brief-treatment/mhl003

Florsheim, P., Shotorbani, S., Guest-Warnick, G., Barratt, T., & Hwang, W. C. (2000). Role of the working alliance in the treatment of delinquent boys in community-based programs. *Journal of Clinical Child Psychology*, *29*(1), 94–107. doi:10.1207/S15374424jccp2901_10

Gaume, J., Bertholet, N., Faouzi, M., Gmel, G., & Daeppen, J. (2010). Counselor motivational interviewing skills and young adult change talk articulation during brief motivational

interventions. *Journal of Substance Abuse Treatment*, *39*(3), 272–281. doi:10.1016/j.jsat.2010.06.010

Gaume, J., Magill, M., Mastroleo, N. R., Longabaugh, R., Bertholet, N., Gmel, G., & Daeppen, J. B. (2016). Change talk during brief motivational intervention with young adult males: Strength matters. *Journal of Substance Abuse Treatment*, *65*, 58–65. doi:10.1016/j.jsat.2016.01.005

Geurts, E. M. W., Boddy, J., Noom, M. J., & Knorth, E. J. (2012). Family-centred residential care: The new reality? *Child & Family Social Work*, *17*(2), 170–179. doi:10.1111/j.1365-2206.2012.00838.x

Gilligan, R. (2015). Foreword. In J. K. Whittaker, J. F. Del Valle, & L. Holmes (Eds.), *Therapeutic residential care for children and youth developing evidence-based international practice* (pp. 11–22). London, UK: Jessica Kingsley Publishers.

Gilman, R., & Anderman, E. M. (2006). The relationship between relative levels of motivation and intrapersonal, interpersonal, and academic functioning among older adolescents. *Journal of School Psychology*, *44*(5), 375–391. doi:10.1016/j.jsp.2006.03.004

Greene, R. W., Ablon, J. S., & Martin, A. (2006). Use of collaborative problem solving to reduce seclusion and restraint in child and adolescent inpatient units. *Psychiatric Services*, *57*(5), 610–612. doi:10.1176/ps.2006.57.5.610

Grooters, G., De Swart, J., Lohuis-Heesink, R., & Moonen, X. (2013). Eind goed, al goed? voortijdige beëindiging van residentiële hulpverlening aan jeugdigen met licht verstandelijke beperking: Omvang en samenhangende factoren [All's well that ends well? premature departure of residential care for youth with mild intellectual disabilities: Prevalence and co-occuring factors]. *Onderzoek & Praktijk*, *11*, 6–16.

Harder, A. T. (2011). *The downside up? A study of factors associated with a successful course of treatment for adolescents in secure residential care (doctoral dissertation)*. Groningen, The Netherlands: University of Groningen.

Harder, A. T. (2015). Een blik in de glazen bol: Zelfreflectie en de toekomst van de residentiële jeugdzorg [Gaze into a crystal ball: Self-reflection and the future of residential youth care]. In J. Knot-Dickscheit, A. M. N. Huyghen, H. J. M. Janssen, W. J. Post, I. Haakma, & H. Grietens (Eds.), *Orthopedagogiek maakt verschil!: Profiel en toekomst van een discipline in beweging [Orthopedagogy makes a difference! Profile and future of a discipline on the move]*. Leuven, Den Haag: Uitgeverij Acco.

Harder, A. T., Hall, C. J., & Van Nijnatten, C. H. C. J. (Eds.). (2016). *Investigating interactions: The dynamics of relationships between clients and professionals in child welfare*. Antwerpen, Apeldoorn: Garant.

Harder, A. T., Kalverboer, M. E., & Knorth, E. J. (2011). They have left the building: A review of aftercare services for adolescents in residential child and youth care. *International Journal of Child and Family Welfare*, *14*(3–4), 86–104.

Harder, A. T., Knorth, E. J., & Kalverboer, M. E. (2013). A secure base? The adolescent-staff relationship in secure residential youth care. *Child and Family Social Work*, *18*(3), 305–317. doi:10.1111/j.1365-2206.2012.00846.x

Harder, A. T., Knorth, E. J., & Kalverboer, M. E. (2015). Risky or needy? Characteristics of adolescents in secure residential youth care. *International Journal of Offender Therapy and Comparative Criminology*, *59*(10), 1047–1065. doi:10.1177/0306624X14531036

Harder, A. T., Knorth, E. J., & Kalverboer, M. E. (2017a). The inside out? views of young people, parents, and professionals regarding successful secure residential care. *Child and Adolescent Social Work Journal*, *34*, 431–441. doi:10.1007/s10560-016-0473-1

Harder, A. T., Knorth, E. J., Kalverboer, M. E., Tausendfreund, T., & Knot-Dickscheit, J. (2017b). Parental perspectives: Risk and protective factors associated with parenting quality

for parents of adolescents in secure residential care. *Child and family social work*. doi:10.1111/cfs.12404

Harder, A. T., Knorth, E. J., & Zandberg, T. (2006). *Residentiële jeugdzorg in beeld: Een overzichtsstudie naar de doelgroep, werkwijzen en uitkomsten [Residential youth care in the picture: A review study of its target group, methods and outcomes]*. Amsterdam, The Netherlands: SWP Publishers.

Hellinckx, W. (2002). Residential care: Last resort or vital link in child welfare? *International Journal of Child and Family Welfare*, *5*, 75–83.

Henriksen, A., Degner, J., & Oscarsson, L. (2008). Youths in coercive residential care: Attitudes towards key staff members' personal involvement, from a therapeutic alliance perspective. *European Journal of Social Work*, *11*(2), 145–159. doi:10.1080/13691450701531976

James, S. (2011). What works in group care? – A structured review of treatment models for group homes and residential care. *Children and Youth Services Review*, *33*(2), 308–321. doi:10.1016/j.childyouth.2010.09.014

Jensen, C. D., Cushing, C. C., Aylward, B. S., Craig, J. T., Sorell, D. M., & Steele, R. G. (2011). Effectiveness of motivational interviewing interventions for adolescent substance use behavior change: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *79*(4), 433–440. doi:10.1037/a0023992

Kane, G. A., Wood, V. A., & Barlow, J. (2007). Parenting programmes: A systematic review and synthesis of qualitative research. *Child: Care, Health and Development*, *33*(6), 784–793. doi:10.1111/j.1365-2214.2007.00750.x

Karver, M. S., Handelsman, J. B., Fields, S., & Bickman, L. (2005). A theoretical model of common process factors in youth and family therapy. *Mental Health Services Research*, *7*(1), 35–51. doi:10.1007/s11020-005-1964-4

Karver, M. S., Handelsman, J. B., Fields, S., & Bickman, L. (2006). Meta-analysis of therapeutic relationship variables in youth and family therapy: The evidence for different relationship variables in the child and adolescent treatment outcome literature. *Clinical Psychology Review*, *26*(1), 50–65. doi:10.1016/j.cpr.2005.09.001

Knorth, E. J., Harder, A. T., Huyghen, A. M. N., Kalverboer, M. E., & Zandberg, T. (2010). Residential youth care and treatment research: Care workers as key factor in outcomes? *International Journal of Child and Family Welfare*, *13*(1–2), 49–67.

Knorth, E. J., Harder, A. T., Zandberg, T., & Kendrick, A. J. (2008). Under one roof: A review and selective meta-analysis on the outcomes of residential child and youth care. *Children and Youth Services Review*, *30*(2), 123–140. doi:10.1016/j.childyouth.2007.09.001

Kromhout, M. (2002). *Marokkaanse jongeren in de residentiële hulpverlening [Morrocan youth in residential care] (doctoral dissertation)*. Amsterdam, The Netherlands: SWP Publishers.

Lee, B. R., & McMillen, J. C. (2017). Pathways forward for embracing evidence-based practice in group care settings. *Journal of Emotional and Behavioral Disorders*, *25*(1), 19–27. doi:10.1177/1063426616688210

Leloux-Opmeer, H., Kuiper, C., Swaab, H., & Scholte, E. (2016). Characteristics of children in foster care, family-style group care, and residential care: A scoping review. *Journal of Child and Family Studies*, *25*(8), 2357–2371. doi:10.1007/s10826-016-0418-5

Lipsey, M. W. (2009). The primary factors that characterize effective interventions with juvenile offenders: A meta-analytic overview. *Victims & Offenders*, *4*(2), 124–147. doi:10.1080/15564880802612573

Lundahl, B., & Burke, B. L. (2009). The effectiveness and applicability of motivational interviewing: A practice-friendly review of four meta-analyses. *Journal of Clinical Psychology*, *65*(11), 1232–1245. doi:10.1002/jclp.20638

Lundahl, B. W., Kunz, C., Brownell, C., Tollefson, D., & Burke, B. L. (2010). A meta-analysis of motivational interviewing: Twenty-five years of empirical studies. *Research on Social Work Practice*, *20*(2), 137–160. doi:10.1177/1049731509347850

Lyons, J. S., Obeid, N., & Cummings, M. (2015). Needs and characteristics of high-resource using youth: North america. In J. K. Whittaker, J. F. del Valle, & L. Holmes (Eds.), *Therapeutic residential care for children and youth developing evidence-based international practice* (pp. 62–70). London, UK: Jessica Kingsley Publishers.

Magill, M., Gaume, J., Apodaca, T. R., Walthers, J., Mastroleo, N. R., Borsari, B., & Longabaugh, R. (2014). The technical hypothesis of motivational interviewing: A meta-analysis of MI's key causal model. *Journal of Consulting and Clinical Psychology*, *82*(6), 973–983. doi:10.1037/a0036833

Markland, D., Ryan, R. M., Tobin, V. J., & Rollnick, S. (2005). Motivational interviewing and self-determination theory. *Journal of Social & Clinical Psychology*, *24*(6), 811–831. doi:10.1521/jscp.2005.24.6.811

Marsh, S. C., & Evans, W. P. (2009). Youth perspectives on their relationships with staff in juvenile correction settings and perceived likelihood of success on release. *Youth Violence and Juvenile Justice*, *7*(1), 46–67. doi:10.1177/1541204008324484

McCurdy, B. L., & McIntyre, E. K. (2004). 'And what about residential…?' Reconceptualizing residential treatment as a stop-gap service for youth with emotional and behavioural disorders. *Behavioural Interventions*, *19*, 137–158. doi:10.1002/bin.151

McLeod, B. D. (2011). Relation of the alliance with outcomes in youth psychotherapy: A meta-analysis. *Clinical Psychology Review*, *31*(4), 603–616. doi:10.1016/j.cpr.2011.02.001

Miller, L. S., & Gramzow, R. H. (2016). A self-determination theory and motivational interviewing intervention to decrease racial/ethnic disparities in physical activity: Rationale and design. *BMC Public Health*, *16*, 768. doi:10.1186/s12889-016-3413-2

Miller, W. R., & Rollnick, S. (Eds.). (2002). *Motivational interviewing: Preparing people for change*. New York, NY: The Guilford Press.

Miller, W. R., & Rollnick, S. (2004). Talking oneself into change: Motivational interviewing, stages of change, and therapeutic process. *Journal of Cognitive Psychotherapy*, *18*(4), 299–308. doi:10.1891/jcop.18.4.299.64003

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd ed.). New York, London: Guilford Press.

Mohr, W. K., Martin, A., Olson, J. N., Pumariega, A. J., & Branca, N. (2009). Beyond point and level systems: Moving toward child-centered programming. *The American Journal of Orthopsychiatry*, *79*(1), 8–18. doi:10.1037/a0015375

Mohr, W. K., & Pumariega, A. J. (2004). Level systems: Inpatient programming whose time has passed. *Journal of Child and Adolescent Psychiatric Nursing*, *17*(3), 113–125. doi:10.1111/jcap.2004.17.issue-3

Moyers, T. B., & Martin, T. (2006). Therapist influence on client language during motivational interviewing sessions. *Journal of Substance Abuse Treatment*, *30*(3), 245–251. doi:10.1016/j.jsat.2005.12.003

Moyers, T. B., Martin, T., Manuel, J. K., Hendrickson, S. M. L., & Miller, W. R. (2005). Assessing competence in the use of motivational interviewing. *Journal of Substance Abuse Treatment*, *28*(1), 19–26. doi:10.1016/j.jsat.2004.11.001

Moyers, T. B., Miller, W. R., & Hendrickson, S. M. L. (2005). How does motivational interviewing work? Therapist interpersonal skill predicts client involvement within motivational interviewing sessions. *Journal of Consulting and Clinical Psychology*, *73*(4), 590–598. doi:10.1037/0022-006X.73.4.590

Moyers, T. B., Rowell, L. N., Manuel, J. K., Ernst, D., & Houck, J. M. (2016). The motivational interviewing treatment integrity code (MITI 4): Rationale, preliminary

reliability and validity. *Journal of Substance Abuse Treatment*, *65*, 36–42. doi:10.1016/j.jsat.2016.01.001

Naar-King, S., & Suarez, M. (2011). *Motivational interviewing with adolescents and young adults*. New York, NY: Guilford.

Oliver, E. J., Markland, D., Hardy, J., & Petherick, C. M. (2008). The effects of autonomy-supportive versus controlling environments on self-talk. *Motivation & Emotion*, *32*, 200–212. doi:10.1007/s11031-008-9097-x

Petrosino, A., Turpin-Petrosino, C., & Buehler, J. (2003). Scared straight and other juvenile awareness programs for preventing juvenile delinquency: A systematic review of the randomized experimental evidence. *The Annals of the American Academy of Political and Social Science*, *589*(1), 41–62. doi:10.1177/0002716203254693

Ryan, R. M., & Deci, E. L. (2000a). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, *55*, 68–78. doi:10.1037/0003-066X.55.1.68

Ryan, R. M., & Deci, E. L. (2000b). Intrinsic and extrinsic motivations: Classic definitions and new directions. *Contemporary Educational Psychology*, *25*(1), 54–67. doi:10.1006/ceps.1999.1020

Ryan, R. M., & Deci, E. L. (2000c). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *The American Psychologist*, *55*(1), 68–78. doi:10.1037/0003-066X.55.1.68

Ryan, R. M., & Deci, E. L. (2008). A self-determination approach to psychotherapy: The motivational basis for effective change. *Canadian Psychology*, *49*(3), 186–193. doi:10.1037/a0012753

Ryan, R. M., Lynch, M. F., Vansteenkiste, M., & Deci, E. L. (2010). Motivation and autonomy in counseling, psychotherapy, and behavior change: A look at theory and practice. *The Counseling Psychologist*, *39*(2), 193–260. doi:10.1177/0011000009359313

Schwalbe, C. S., Oh, H. Y., & Zweben, A. (2014). Sustaining motivational interviewing: A meta-analysis of training studies. *Addiction*, *109*(8), 1287–1294. doi:10.1111/add.12558

Shirk, S. R., & Karver, M. (2003). Prediction of treatment outcome from relationship variables in child and adolescent therapy: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *71*(3), 452–464. doi:10.1037/0022-006X.71.3.452

Slot, N. W., & Spanjaard, H. J. M. (1999). *Competentievergroting in de residentiële jeugdzorg: Hulpverlening voor kinderen en jongeren in tehuizen [Expanding competency in residential child and youth care: Support for children and young people in residential homes and institutions]*. Baarn, The Netherlands: Intro Publishers.

Slump, G. J. (2011). *Handelen door professionals in de jeugdzorg: Om kracht verlegen? [Acting by youth care professionals: In need of strength?]*. Zwolle, The Netherlands: Zin in jeugdzorg.

Strang, J., & McCambridge, J. (2004). Can the practitioner correctly predict outcome in motivational interviewing? *Journal of Substance Abuse Treatment*, *27*(1), 83–88. doi:10.1016/j.jsat.2004.05.003

Teixeira, P. J., Palmeira, A. L., & Vansteenkiste, M. (2012). The role of self-determination theory and motivational interviewing in behavioral nutrition, physical activity, and health: An introduction to the IJBNPA special series. *The International Journal of Behavioral Nutrition and Physical Activity*, *9*, 17. doi:10.1186/1479-5868-9-17

Thompson, R. W., & Daly, D. L. (2015). The family home program: An adaptation of the teaching family model at boys town. In J. K. Whittaker, J. F. Del Valle, & L. Holmes (Eds.), *Therapeutic residential care for children and youth developing evidence-based international practice* (pp. 113–123). London, UK: Jessica Kingsley Publishers.

Turney, D. (2012). A relationship-based approach to engaging involuntary clients: The contribution of recognition theory. *Child & Family Social Work*, *17*(2), 149–159. doi:10.1111/j.1365-2206.2012.00830.x

Van Binsbergen, M. H. (2003). *Motivatie voor behandeling: Ontwikkeling van behandelmotivatie in een justitiële instelling [Motivation for treatment: Development of motivation for treatment in a secure residential facility] (doctoral dissertation)*. Leiden, The Netherlands: University of Leiden.

Van Dam, C., Nijhof, K. S., Veerman, J. W., Engels, R. C. M. E., Scholte, R. H. J., & Delsing, M. J. M. H. (2011). Group care worker behavior and adolescents' internalizing and externalizing problems in compulsory residential care. *Residential Treatment for Children & Youth*, *28*(3), 232–250. doi:10.1080/0886571X.2011.605050

VanderVen, K. (1995). "Point and level systems": Another way to fail children and youth. *Child and Youth Care Forum*, *24*(6), 345–367. doi:10.1007/BF02128526

Vansteenkiste, M., & Sheldon, K. M. (2006). There's nothing more practical than a good theory: Integrating motivational interviewing and self-determination theory. *British Journal of Clinical Psychology*, *45*(1), 63–82. doi:10.1348/014466505X34192

Vansteenkiste, M., Williams, G. C., & Resnicow, K. (2012). Toward systematic integration between self-determination theory and motivational interviewing as examples of top-down and bottom-up intervention development: Autonomy or volition as a fundamental theoretical principle. *International Journal of Behavioral Nutrition and Physical Activity*, *9*(1), 23. doi:10.1186/1479-5868-9-23

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, *14*(3), 270–277. doi:10.1002/wps.20238

Whittaker, J. K., Del Valle, J. F., & Holmes, L. (Eds.). (2015). *Therapeutic residential care for children and youth developing evidence-based international practice*. London, UK: Jessica Kingsley Publishers.

Whittaker, J. K., Holmes, L., Del Valle, J. F., Ainsworth, F., Andreassen, T., Anglin, J., … Zeira, A. (2016). Therapeutic residential care for children and youth: A consensus statement of the international work group on therapeutic residential care. *Residential Treatment for Children & Youth*, *33*(2), 89–106. doi:10.1080/0886571X.2016.1215755

Wigboldus, E. H. M. (2002). *Opvoedend handelen in een justitiële jeugdinrichting: Systematisering van het behandelaanbod binnen rentray [Child rearing in a judicial youth institution: Systematization of the care program at the rentray treatment center] (doctoral dissertation)*. Leuven, Apeldoorn: Garant.